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WHAT IS COMPLICATED GRIEF? A SOCIAL CONSTRUCTIONIST PERSPECTIVE

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ABSTRACT

Research into complicated grief assumes that it is a psychological disorder of the grieving individual. This article suggests seven other things that complicated grief may also be: a normalizing construct of psychiatric medicine, an operational requirement of bereavement agencies, a concept by which society as a whole and families can discipline mourning members, a label applied to those who actively resist cultural norms about grief, a product of a society obsessed with risk, and the result of negotiation between various parties in the bereavement field. If complicated grief exists, it is much more multi-faceted than is usually acknowledged.

Grief, like death itself, is undisciplined, risky, wild. That society seeks to discipline grief, as part of its policing of the border between life and death, is predictable, and it is equally predictable that modern society would medicalize grief as the means of policing (Foote & Frank, 1999, p. 170).

INTRODUCTION

Though they disagree over details, the other contributors to this special issue all agree that pathological grief exists, and that it should be possible to differentiate pathological from normal grief. In their view, complicated grief exists within the psyche of the individual mourner. I suggest that this over-simplifies, and in this article I outline a number of apparently competing, but perhaps ultimately complementary, views of what complicated grief is.

Clearly, grief—a multi-dimensional range of experiences following a loss (Bonanno, 2001, pp. 494-495)—exists. Clearly, grief varies widely in its nature, intensity and duration. Some grief—for example, after the Boxing Day 2004 Tsunami where people lost multiple family members, their home, their livelihood, their trust in an orderly world—is almost unbelievably complex, traumatic and potentially disabling. But why divide the wide range of grief into two simple binary categories of normal versus pathological, or uncomplicated versus complicated? Or indeed, why cut the cake of grief into four slices—uncomplicated, complicated, depressive, PTSD?

As the quote with which I began says, “Grief is undisciplined, risky, wild.” Ariès (1981) has argued that Western society has over the past millennium tried to tame grief in very different ways, represented in medieval masses for the dead, Renaissance works of art, Puritan sermons, the nineteenth century Romantic movement, and twentieth century psychology. If the phenomenon of complicated grief is a dis-order (Hogan, Worden, & Schmidt, 2003-2004; Horowitz et al., 1997; Prigerson et al., 1995), then the notion of “complicated grief” is a way of re-inserting cognitive order into the disorder, making sense of what experientially is chaotic. But why re-order the chaos using this particular concept, or indeed any of the concepts that are variants on the notion of “pathological grief”?

So, here are eight possible answers to the question “What is complicated grief?”

EIGHT ANSWERS

1) CG is a Psycho-Pathology of the Individual Mourner

The vast majority of the literature on complicated grief assumes that it is a psychological property, or set of properties, of the individual mourner. In Prigerson’s criteria for diagnosing complicated grief, for example, the sufferer experiences prolonged yearning, heartache, lack of trust, numbness, and a sense of emptiness. These internal pathologies may be exacerbated by external lack of social support.

That said, researchers and clinicians are only interested because they believe these properties indicate something outside the internal psyche, namely they are “associated with or predictive of impaired performance in daily activities (that is, they result in complications in normal functioning)” (Prigerson et al., 1995, p. 23). This, of course, is the case with all mental and physical illnesses, as conceptualized by Western medicine: researchers seek the properties of the common cold, or lung cancer, or schizophrenia because these diseases are associated with impaired physical, mental, or social performance. These diseases are (lay and/or scientific) constructs generated to explain poor functioning and suffering. These constructs hold that the disease resides within the individual body, visible only (if at all) via medical technologies; the internal disease explains the externally visible symptoms and poor functioning. Disease categories (such as colds, cancer, and

schizophrenia) are typically formulated and accepted long before their detailed causation, bio-chemistry or other mechanisms are understood.

2) CG is a Construct of a “Normalizing” Medicine

In the nineteenth century, grief was a condition of the human spirit or soul. It might sometimes be viewed as a cause of insanity, but it was not itself a mental illness (Prior, 1989, p. 135). This understanding of grief as a human misfortune, rather than a mental illness, was shared by Freud, as has been noted by Foote and Frank (1999) and Stroebe et al. (2000). It was Lindemann’s (1944) seminal article that began the trend toward using psychiatric terminology to describe grief. As Foucault (1973, 1975) has cogently shown, the distinction between the normal and pathological is the central intellectual device of psychiatric medicine, so once grief became medicalised and psychiatrized, it was inevitable *either* that all grief would be seen as a mental illness (Parkes, 1965, p. 1)¹ *or* that distinctions between normal and abnormal grief would be made and elaborated. Overwhelmingly, it is the latter that has occurred over the past forty years.

So, whether or not complicated grief resides within the individual mourner, it certainly does reside within a Western psychiatry whose job it is to normalize and pathologize.

3) CG is an Operational Requirement of Bereavement Agencies

In a country like the United States or the United Kingdom, millions of people are bereaved each year. Bereavement agencies will never have the resources to work with them all, even if they were asked to and/or wanted to. Of course, they could just work with clients who seek their services, but it is quite possible that those who are in most need may not seek help (Prigerson, 2004, p. 39) or that demand for their services outstrips supply. In this case, agencies need objective criteria by which they can allocate scarce resources so that they work with those in most need. And in certain countries such as the United States, agencies need objective diagnosis of psychiatric need if they are to receive reimbursement from health insurance. Organizations that use volunteer and only minimally trained counsellors may work with clients suffering normal grief, passing cases of more complicated grief onto more highly trained therapists and psychiatrists. One British family doctor writes “I do some basic counselling myself but I refer more complicated cases to Cruse” (Porter, 1996)—so the concept of complicated grief can be used both to refer a client to a voluntary agency, and for that agency to refer the client onto more professional help. There is therefore

¹ In one sense I agree with Parkes. Grief, like falling in love, does drive us temporarily mad. But whereas grief has led to extensive psychiatric research, categorization and intervention, falling in love has not—grief has become medicalized, falling in love has not.

a very real sense in which social or psychological need is less a property of individual clients than of organisations that must ration scarce resources and that must refer clients on when their workers get out of their depth (Smith, 1980).

4) CG is a Cultural Concept

Although terms such as complicated or pathological grief are generated by and found within psychiatric science and bereavement organizations, these terms also reflect powerful processes within the wider culture. Every society has its norms, and identifies and labels deviance from those norms (Becker, 1963). Grief is no exception. Every society has norms about the proper and acceptable way to grieve. Walter (1999) argues that these grief norms operate along two main dimensions: a) What should be done with the painful and powerful emotions of grief? Should they be expressed or contained? If expressed, should this be personal (as in contemporary grief literature), or within ritual formats (as in Greek or Ingrian laments) (Danforth, 1982; Nenola-Kallio, 1982)? b) To what extent should mourners spend their time with the dead, or with the living? Is contact with the dead expected (as in ancestor veneration) or taboo (as in Protestantism)? Cultures also vary on how long grief should last, something which Gorer (1965) also highlighted in his classic survey of English attitudes to grief. So each culture is able to identify mourners who obey the rules, and those who do not.

There is a surprising similarity between some technical descriptions of complicated grief and popular cultural norms. Though Prigerson and Jacobs (2001) deny that complicated grief is just chronic, i.e., over-prolonged, grief, it seems that this is precisely what their delineation of complicated grief is. Their criteria for complicated grief include, for example, intrusive thoughts about the deceased, yearning for the deceased, searching for the deceased, loneliness as a result of the death, feelings of futility about the future, numbness, feeling life is empty, feeling that part of oneself has died, impaired functioning in social, occupational or other important areas (p. 629). Many mourners have such experiences; the only thing that qualifies this cluster of experiences as indicative of complicated grief is that they last, at any one time, for more than two months. This reflects popular notions that grief is something one should get over quickly, and that it is embarrassing and/or inconvenient if colleagues' or family members' functioning is impaired by grief for extended periods. Indeed, it reflects a widespread duty in American culture for its members to be self-determining individuals and, moreover, happy.

There is therefore some credibility in Foote and Frank's (1999, p. 180) argument that pathological grief is diagnosed when a mourner's feelings do not fit the dominant discourse of grief. In their view, what is required is a narrative therapy which enables the client to critique the dominant discourse so that s/he can internalize a narrative more congruent with their own feelings. In other words,

in the mismatch between individual feeling and dominant discourse, it is the latter which is at fault. That this is not the view of many researchers into pathological grief is hinted at by Prigerson and Jacobs (2001, p. 615): “We avoided the terms pathologic, neurotic, distorted, morbid, and abnormal grief because these adjectives seemed somewhat derogatory and value-laden.” For those who use such terms, it is clearly the mourner, not society, that is the problem. Though “complicated grief” seems at first to avoid such value judgments, my preceding paragraph shows this is not actually the case: “complicated” means grief that is too intense, too long, and impairs functioning.

5) CG is a Label Families Use to Control Deviant Members

Though there are cultural norms about grief, this is not to say there is consensus within a society. Individual families can have their own norms, and when two people from different families of origin get married there is plenty of scope for different understandings of appropriate grief between the partners. This is exacerbated by gender differences in preferred styles of mourning (Stroebe, 1998; Walter, 1999, pp. 168-184), not to mention individual differences in attachment or coping style. Although much has been written about the medicalization of grief, it is far more common in modern societies for bereaved individuals to feel pressured by other family members, rather than by psychiatry, to grieve in a certain way (Walter, 2000). The rank and file of the grief police are not doctors, psychiatrists, and counsellors; they are ordinary family members in ordinary families. Both lay and semi-psychiatric notions of abnormality can be invoked (usually unsuccessfully) to try to bring the deviant mourner back into line, for example by suggesting they need help. We may compare here the (now unfashionable) investigations of the anti-psychiatry movement into how more powerful members of a dysfunctional family can scapegoat and label one member as mad (Laing, 1967; Scheff, 1966).

6) CG is a Label Applied to Those Who Resist Cultural Norms

In a section titled “Complicated Mourning as Resistance,” Foote and Frank (1999, pp. 171-177) suggest that complicated grief is a way of resisting dominant discourses about grief. Though some labelled as suffering complicated grief are certainly resisting dominant discourses, I would not go so far as to say that all are. This smacks too much of a naïve neo-Marxism in which every suffering or disadvantaged individual, every petty delinquent or homeless person, is heroically resisting the system.

The political aspect of “complicated grief” is, however, shown when we consider mourners who become campaigners. A key text here is Holst-Warhaft’s *Cue for Passion: Grief and Its Political Uses* (2000) in which she shows how

the anger of grief has on numerous occasions throughout history been used to transform society. A fairly recent example is the Mothers of the Plaza de Mayo, the mothers of Argentina's disappeared, who refused to be bought off with (probably fake) bones being returned to them and with talk of the need for "closure." As their newspaper wrote: "Let there be no healing of wounds. Let them remain open. Because if the wounds still bleed, there will be no forgetting and our strength will continue to grow" (p. 117). Only thus is a corrupt government changed. Almost certainly the Mothers of the Plaza de Mayo fitted the criteria for complicated grief—for years they had intrusive thoughts about the deceased, searched for the deceased, felt that part of themselves had died, showed extreme anger, lost their sense of trust, etc, etc. Should we be worried about them? Should professionals intervene and get them more balanced? As soon as we ask such questions, we see that this would be akin to sending dissenters in the old Soviet system off to remote mental hospitals in Siberia. Rather, for these mothers, having a tough time psychologically was not pathological but a price they willingly paid for the sake of creating a more healthy society.

We begin now to see that "complicated grief" may, possibly, be a useful concept in a healthy, democratic, open society, but in societies in which millions die because they are disappeared by the government (as in Argentina), or because they are killed by neo-colonial powers (as in Iraq), or because the government does not acknowledge the realities of AIDS (as in South Africa), CG is a very dangerous concept. Mourners' prolonged and obsessive anger, searching, and loss of trust are not psychological abnormalities to be therapied away, but precisely the motors that may lead to a more just society.

7) CG is a Product of the Risk Society

Research into complicated grief aims to identify risk factors. Though normal grief may last a year or two, humanity dictates that the clinician or agency not wait two years till identifying the person at risk of complicated grief. If CG and its associated suffering can be treated, it should be identified and treated earlier rather than later (Prigerson & Jacobs, 2001, pp. 620-621). This can be understood as part of a culture that Beck has termed "the risk society" (1992), a society obsessed with predicting and eliminating risk, guaranteeing safety and even happiness, a society unable to accept suffering. This may be contrasted with both Buddhism, which takes human suffering as its starting point, and Christianity which sees a redemptive potential in suffering. Both Buddhism and Christianity have inspired a fundamental tenet of palliative care, of being with the dying person in the present, of refusing to categorize (Ostaseski, 1990), accepting there may be no answer (Lunn, 1990), or no control over events (Vanstone, 1982). This seems at odds with a predictive science that presumes to know in advance of the person themselves that they need help, and with an expert therapy that presumes to provide that help.

Complicated grief is dis-ordered grief, and modernity has difficulty with dis-order.² The notion of “complicated grief” attempts to find reason in the dis-order, and thus to begin re-ordering. It offers what Frank (1995) terms a restitution narrative—yesterday I was well, today I am sick, tomorrow I will be well again. But, whether inspired and emboldened by Buddhism, Christianity or even postmodernism, perhaps a more helpful aim is not restitution but acceptance of the legitimacy of chaos (Foote & Frank, 1999, p. 180), attained by developing a quest story that meets suffering head on, accepts illness, and seeks to use it (Frank, 1995, p. 115). Maybe it is not just the Mothers of the Plaza de Mayo that need to challenge society.

8) CG is Negotiated between Researchers, Agencies, and Clients

From what I have said so far, it is clear that a number of parties—researchers, clinicians, family doctors, bereavement organizations, mourners, other family members, the wider culture—all have an interest in notions of pathological grief. Their interest may be in promoting it, or resisting it. Most likely, therefore, what eventuates will be the result of negotiations between these various parties, negotiations in which some parties have more power than others. Psychiatry does not exist separate from wider cultural notions about proper grieving or from the risk society; mourners live in families; organizations need to present clinical need in terms that meet reimbursement requirements.

CONCLUSION

So, does complicated grief exist? I suggest it does, but to see it existing just in sense 1) is to miss its multi-faceted nature. Complicated grief is a multi-dimensional phenomenon that exists within and is negotiated through the power relationships that link researchers, clinicians, reimbursers, clients and families. Grief—like madness, trauma, homicide, sexuality, and homosexuality—exists, but how we normalize and pathologize it is a social construct. Homosexuality, for example, has been seen as sin, as disease, and as personal choice. Grief too has been seen in a variety of ways. Complicated grief is one way; it is a social construct, and a highly complicated one!³

I am not a psychiatrist or psychologist, nor a clinician. A month before I was invited to contribute to this special issue, the latest copy of *Bereavement Care* was delivered through my letter box. In it I found Prigerson’s (2004) non-technical summary of her findings about complicated grief, and I found myself reading it with increasing interest, not at that time because of any academic or clinical

² I say this with considerable sympathy. I too like order.

³ For studies of grief as a social construct, see Fowlkes (1990), Lofland (1985), Wambach (1985).

interest, but because I was concerned about a friend who was taking a particular loss very hard. I feared her grief would prove, in the words of the quote with which this article began, “undisciplined, risky, wild.” Seeking clues as to whether she was at significant risk, I found myself drawn into the article; Prigerson offered clear and simple diagnostic criteria that even a layperson could use. This illustrates what I have been arguing here: the roots of complicated grief lie not just in the individual mourner’s psyche, but also in the concern of family and friends to reduce suffering, to get the mourner back to autonomy and happiness, to reduce their own inconvenience and worry, to replace chaos and guilt with order and predictability. Without such concern, there would be no concept of complicated grief. There are other roots in normalizing psychiatry and the organizational needs of bereavement agencies. It is such things that lead us to see some grief as uncomplicated, and some as complicated. Complicated grief is a function of our concern as much as of the mourner’s psychology, and can be understood only as an interaction between the two.

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